MDR Tracking Number: M5-05-0320-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution – General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-22-04.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 8-27-03 through 9-19-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, electrical stimulation, functional capacity evaluation and work conditioning program from 9-22-03 through 1-26-04 were not medically necessary.

On 11-2-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT codes 97545-WC and 97546-WC from 10-28-03 through 11-26-03 were denied by the insurance carrier as "R" – The service is for a condition which is not related to the covered work related injury. On 2-3-04 a BRC ruled that the compensable injury is a low back sprain/strain. One of the diagnosis codes on the EOB for these dates of service is 847.2 – lumbar sprain and strain. This treatment is compensable. **Recommend reimbursement per Rule 134.202(e)(5) of $5,904.00.**

CPT codes 97545-WC and 97546-WC from 12-01-03 through 12-10-03 were denied by the insurance carrier on an audit dated 2-4-04 as "V" – Unnecessary Medical Treatment on the Explanation of Benefits with an audit date of 2-4-04. The IRO ruled that these services were not medically necessary. The insurance carrier denied these services on an audit dated 4-29-04 as "R" – this condition is not related to the work related injury. On 2-3-04 a BRC had ruled that the compensable injury is a low back sprain/strain which was the condition identified on the EOB. In accordance with Rule 134.600 (h) (4), the requestor had also provided a copy of the preauthorization letter dated 10-28-03 for 70 hours of work conditioning. **Recommend reimbursement of $1,980.00.**

CPT code 97750-FC on 12-16-03 was denied as "F" – This claim was previous submitted and reviewed with notification of decision issued to payor/provider. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of $288.00.**

CPT code 99212 on 1-6-04 was denied as "F" – This claim was previous submitted and reviewed with notification of decision issued to payor/provider. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of $45.00.**

CPT code 99211 on 1-22-04 was denied by the insurance carrier as "R" – The service is for a condition which is not related to the covered work related injury. On 2-3-04 a BRC ruled that the compensable injury is a low back sprain/strain. The diagnosis on the EOB with an audit date of 7-12-04 for this date of service is 847.2 – lumbar sprain and strain. This treatment is compensable. **Recommend reimbursement of $26.00.**

CPT code 99455-VR on 1-23-04 was denied by the insurance carrier as "R" – The service is for a condition which is not related to the covered work related injury. On 2-3-04 a BRC ruled that the compensable injury is a low back sprain/strain. The diagnosis on the EOB with an audit date of 7-12-04 for this date of service is 847.2 – lumbar sprain and strain. This treatment is compensable. **Recommend reimbursement per Rule 134.202 (e)(6)(D) of $50.00.**

This Finding and Decision is hereby issued this 5th day of April 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling $8,293.00 for dates of service 10-28-03 through 1-23-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is hereby issued this 5th day of April 2005.

Margaret Ojeda, Manager
Medical Necessity Team
Medical Dispute Resolution
Medical Review Division

MO/da

Enclosure: IRO Decision

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758
Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 15, 2004

Re: IRO Case # M5-05-0320-01 amended 3/14/05 and 3/25/05 due to incorrect assignment sheet and two requests for two different changes of requested services

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed in Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits
3. IME 8/12/03
4. Peer review 6/30/03
5. Health carrier's position statement
6. Preauthorization request
7. FCE report 9/30/03
8. PPE report 11/10/03
9. Work conditioning daily notes and progress reports

10. D.C. treatment notes
11. TWCC work status reports
12. Requests for reconsideration 2/4/04, /9/04
13. MRI of lumbar spine report 6/20/03
14. IR report 1/8/04
15. Report 6/19/03
16. Report 6/20/03

History
The patient injured his lower back in ___ when he slipped and fell while digging a ditch. He initially saw his company doctor, and then he sought chiropractic treatment. The patient has been treated with medication, chiropractic treatment, therapeutic exercises and a work hardening/conditioning program.

Requested Service(s)
Work conditioning, work conditioning each additional hour, office visits, therapeutic exercises, electrical stimulation
FCE 9/22/03 – 1/26/04

Decision
I agree with the carrier's decision to deny the requested services.

Rationale
The patient received an adequate trial of conservative treatment prior to the conditioning program with minimal changes in his initial objective findings and subjective complaints. The D.C.'s treatment notes prior to the work hardening/work conditioning program lacked subjective complaints and objective findings to support the services prior to the dates in dispute.
Based on the records provided for this review, I agree with the 6/30/03 report and the IME report that stated that six to eight weeks of conservative therapy would be reasonable for the patient's lumbar sprain/strain injury. Neither report mentioned the necessity of a work conditioning program.
The patient had a documented sprain/strain injury superimposed on multilevel degenerative disk changes and a congenital fusion at T11-12. His injury should have resolved with appropriate treatment prior to the work hardening/work conditioning program started, but treatment failed to relieve symptoms or improve function prior to the start of the program. Failed conservative therapy does not establish a medical rational nor additional therapy such as a work conditioning program or the other requested services.
Given the limited, poor response to a supervised therapy program, a work conditioning program and the other requested services were not medically indicated, nor were they supported by the documentation provided for this review. The need for work conditioning programs is usually based on a good response to past treatment.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

_____
Daniel Y. Chin, for GP